Payment Reform Pilot Application
St. Johnsbury Oncology Pilot
Submitted for Approval by the GMCB
June 21, 2012

General information

Please name the provider group(s) or organization(s) participating in the pilot and their qualifications to manage the pilot:

The following organizations and providers have agreed to participate in the St. Johnsbury Oncology Pilot. All of these providers are experienced in the delivery of primary care and specialty services to residents of the St. Johnsbury area. The purpose of this pilot is to provide the resources and support to these providers to better coordinate and improve health care services to patients diagnosed with cancer.

1. **Northern Counties Health Care**
    a. Caledonia Internal Medicine: Jordice G. Corey - FNP, PCP
    b. Concord Health Center: Sarah E. Berrian - MD, PCP, Mary O. Ready - MD, PCP and Susan G. Taney - NP, PCP
    c. Danville Health Center: Sharon D. Fine – MD, PCP, Timothy H. Tanner – MD, PCP and Mariel K. Hess – NP, PCP
    d. St. Johnsbury Family Health Center: John M. Ajamie – MD, PCP, Dana C. Kraus – MD, PCP, Carey J. Brodzinski – NP, PCP, Cathleen W. Besch – NP, PCP and Diane E. Matthews – NP, PCP
2. **Northern Vermont Regional Hospital**
    a. Kingdom Internal Medicine: Thomas Ziobrowski – MD, PCP, Frank Meierdiercks – MD, PCP, Claudia Lee – MD, PCP and Jessica MacLeod – AG, PCP
    b. Corner Medical: Thomas Broderick – DO, PCP, Brigitte Dargis – MD, PCP, Joyce M. Dobbertin – MD, DC, PCP, Susan P Erisman – MD, PCP, Susan Gresser – MD, PCP, Albert J. Hebert – MD, PCP, Lori Koshowski – ANP, PCP, John G. Scott – MD, PHD, PCP and Miriam Simon – PA-C, PCP
    c. NVRH: Christopher Danielson – DO, General Surgery, Kenneth Danielson – MD, General Surgery, Martin Walko – MD, General Surgery, Terry Larsen – MD, General Surgery, Andrew Nisbet – MD, General Surgery, Elaine Paul – MD, General Surgery, Gailyn Thomas – MD, General Surgery and Karen Kenny – MD, General Surgery
3. **Norris Cotton Cancer Center**
    a. Gregory Ripple – MD, Medical Hematology/Oncology, Ronald Kubica – MD, Medical Hematology/Oncology, Elizabeth Bengtson – MD, Medical Hematology/Oncology, Frank Schell – MD, Medical Hematology/Oncology, Sergey Devitskiy – MD, Medical Hematology/Oncology, John Peterson – MD, Medical Hematology/Oncology, June Rhoda – ARNP, Medical Hematology/Oncology, John Marshall – MD, Radiation Oncology, Anna Fariss, MD, Radiation Oncology, Phillip Schaner – MC, Radiation Oncology and Claire Pace – ARNP. Radiation Oncology

What are the goals of the project?

The goals of this pilot are to improve the quality of care for patients residing in the St. Johnsbury area who have been diagnosed with cancer, improve patient experience/satisfaction, reduce unnecessary utilization of services and reduce overall expenditures related to this care.

How will the pilot aim to achieve the objectives of reducing the growth of health care expenditures, improving the quality of care for the population, and improving patient experience/satisfaction?

The pilot will involve having providers work collaboratively on health care delivery innovation, including PCPs, oncologists, surgeons, palliative care, and Blueprint Medical Home providers, including members of the Community Health Teams. These providers, working together will develop a comprehensive integrated care plan and supporting communication practices. Payers and providers will collaborate together to develop patient centric delivery protocols and payment models across all provider venues, which are based on adherence to evidence-based clinical protocols and pathways and the elimination of duplicative diagnostic and treatment services.

The pilot will be overseen by a Project Planning and Steering Committee made up of clinical, financial, and administrative representatives from the participating organizations and representatives of the payers participating in the pilot. The role of the committee will be to oversee the planning, implementation, and evaluation of the Pilot over the next three years.

The primary objectives of the Steering Committee will be:

- Develop processes for the creation of Interdisciplinary Care Plans that will define the treatment goals for an individual patient, and describe the roles and responsibilities of the care providers. The Interdisciplinary Care Plan will include primary care, oncology care, and palliative care.
- Develop a care planning process that considers how information will be shared among the care providers, and how the communications process will be restructured to enable the sharing of that information.
- Develop processes for tracking and reporting adherence and variations to NCCN (National Comprehensive Cancer Network) care treatment protocols for breast, prostate, lung, and other cancers defined by the Steering Committee, including processes for corrective and preventive action (CAPA) management.
- Develop appropriate metrics to measure quality and utilization, including total cost of care and clinical outcomes consistent with nationally accepted performance and quality measures. Utilize existing information systems or develop other processes to collect and report this information to the providers on a regularly scheduled basis and in a format that is easily understood and helpful for use in improving performance.
- Develop measures of patient satisfaction and patient experience using currently available tools such as the CAHPS PCMH Patient Survey. Results of these surveys and selected quality performance information should be publicly reported.
- Develop processes for training for participating primary care physicians, specialists and other members that are a part of the clinical delivery team.

What is the scope of services included in the pilot?

The scope of services to be included in the pilot is primary care, specialty care and hospital care for all patients who meet pilot criteria and opt to participate.

What payers are participating in the pilot?

We anticipate that BCBSVT-TVHP (76 Members), MVP Healthcare (19 Members), Medicaid (102 Members), and Cigna (68 Members) will be the initial payers participating in the pilot.

What population will be included in the pilot? How will they be attributed or assigned to the pilot?

See Panelization Criteria for Patients in the Oncology Pilot (Attachment 1)

How will you measure outcomes related to each of the pilot's goals?

Process and outcome measures for each of the participating clinical services will be identified. For primary care the CAHPS/PCMH survey will be abstracted to identify the outcomes related to patient experience, shared decision-making, and symptom management. Adherence to National Comprehensive Cancer Network guidelines and selected American Society of Clinical Oncology/Quality Oncology Practice Initiatives (QOPI) will be used to measure oncology outcomes. Palliative care outcome and process measures will include monitoring of specialized palliative care services (sophisticated symptom control, prognosis, goal setting, and hospice referral rates).

A preliminary list of performance measures established for the goals noted above are:

- Care quality: Clinical Care Plan compliance
- Care quality: Quality performance measures specific to the condition of the patients
- Patient experience: Patient experience metrics from the nationally recognized NCQA CAHPS PCMH Patient Survey
- Utilization Measures TBD :
- Cost Measures TBD :

(Specific measures in each of these categories are currently under development and are planned to be finalized at the end of June 2012 or early July 2012.)

Financial model

What is the general model of payment change you will be testing in this pilot?

Initially, the payment changes will be to provide additional payments to providers for completing a multi-disciplinary care plan for each patient enrolled in the pilot, monitoring performance of providers relative to that care plan, and developing the palliative care resources necessary to support this pilot. Over time we will work with the payers and providers to develop new payment models that would offer opportunities for shared savings and some risk assumption by providers.

Does the pilot necessitate any investment in financial or clinical management capacity or other infrastructure? If so, please describe and quantify the necessary investments?

We are proposing that for the first year of the Pilot, all Payers participating in the Pilot would pay an additional financial incentive to both the participating primary care and specialty practices in an amount of $40.00 per patient per month for each of their respective members who are attributed to the Pilot. These payments would begin when the patient is initially diagnosed and attributed to the Pilot and would continue throughout the period of active treatment, including Palliative Care and Hospice. Payments would be discontinued when the patient is documented to be in a survivorship mode. For example if one of the payers has 60 attributed members, they would be paying $40.00 x 60 x 12 or $28,800 per year to both the primary care practice and the specialty practice for a total of $57,600. If we are able to achieve a 5% savings on anticipated expenditures as a result of the improved service delivery model, the savings would amount to @ $60,000 per year. This financial commitment on the part of the payers would be limited to this specific pilot, and would not be expanded to additional oncology pilots until a full evaluation of the pilot had been completed including the impact on clinical performance, patient experience, and expenditure reduction at least commensurate with the investment of the payers. These payments would be considered a cost of care, and are in addition to the PPPM incentive payments and financial support for the Community Health Teams associated with the Blueprint for Health.

Other investments currently under consideration would include additional resources for investments in HIT improvements in order to support the timely sharing of clinical information and claims data among multiple providers and participating organizations. A specific request for this incentive payment will be developed by the participating organizations and presented to the GMCB.

How will the pilot limit cost increases?

By establishing a multi-disciplinary care plan for each patient, and providing for the monitoring and oversight of that plan, it is anticipated that duplicative tests, and imaging will be reduced and that end of life care will be based on the patient's and family wishes informed through more robust palliative care and hospice programs. A sampling of patient utilization and expenditures is currently being reviewed to identify possible opportunities for these savings. By establishing scientifically based clinical protocols for the diagnosis and ongoing treatment of patients, further reductions in the utilization of ancillary resources and the cost of therapeutic drugs should also occur. Providers will be expected to provide written explanations and clinical documentation of the reasons they have chosen to vary from the previously agreed upon plan of care. Variations of this nature will be reviewed and discussed as part of ongoing educational opportunities for all participating providers. In addition, by introducing a palliative care plan as part of the multi-disciplinary treatment plan, it is anticipated that patients will have more of a voice in their treatment decisions, and will be provided with sufficient information and educational materials to help them choose the treatment options that are consistent with their life style choices and values.

Attachment 3 provides a summary of commercially insured and Medicaid patients who had a diagnosis of cancer (based on the criteria and diagnoses defined by this pilot) in Vermont in 2009. The number of patients is broken out by Payer, and total health care expenditures by payer are displayed over a four year period (2008-2011). The total amount per capita of expenditures by payer is also displayed. These numbers are provided on a statewide basis and for those patients identified in the St Johnsbury geographic area.

There were 9,804 patients identified in the state who would meet the criteria of this pilot, and 270 in the St. Johnsbury area. Total four-year expenditures for this population were $689 million statewide, and nearly $20 million in the St. Johnsbury area. The cost per capita is slightly higher in the St. Johnsbury area at $73,626 compared to $70,335 statewide over a four-year period. Potential savings statewide and for St. Johnsbury over the same period are estimated at 5%, 7% and 10%. We will be working with the payers to reach an agreement on enhanced payments that promise a reasonable opportunity for savings for each of the payers. If the cost per capita in St. Johnsbury was reduced to the Statewide average, the estimated savings would be @$225,000 per year.

***How will financial risk (risk for exceeding the target rate of growth) be assigned under the pilot*?**

There will be no financial risk assigned to the providers during the initial stage of this pilot.

How are you proposing to share any financial savings that might be achieved through the pilot?

There are currently no plans to offer shared savings opportunities for the providers during the initial stage of this pilot (year one). The savings realized will accrue to the payers who have invested in the pilot.

How will provider compensation plans be structured within the pilot, and how will they align financial incentives for physicians and other health care practitioners with the performance goals of the pilot?

As mentioned above, initially we are not planning to incorporate any risk sharing arrangements in the Pilot (year one). We expect payers will provide incremental payments in addition to current fee-for-service reimbursement to both primary care and specialty care providers for the development and maintenance of high quality patient specific integrated clinical care plans; for the monitoring of those plans, and for the early provision of patient palliative care services not otherwise reimbursed according to current practice. Over time payers and providers will develop a payment model, which may share risk and savings consistent with new payment and delivery models being developed in other venues throughout the state.

Clinical model

How will Care Management responsibility be assigned or shared under the pilot?

Care management is critical to the success of the pilot. Each patient will have an individualized multi-disciplinary care plan and will be assigned a care coordinator who will be responsible for insuring that the care plan is followed and that any changes in the plan are well documented and shared with all involved providers. Care management resources are intended to be drawn from the practices whenever possible including the Blueprint Community Health Teams. Care management can be supplemented by the payers when situations warrant specialized care management resources (out of area referral, hospice services, etc).

How will the pilot project align with the Blueprint for Health?

All of the Primary Care Practices participating in the Pilot are currently enrolled in the Blueprint for Health. The Community Health Team Members currently assigned to the practices will be expected to play a significant role in improving care coordination and adherence to clinical care plans in this pilot.

Phase II of the Blueprint for Health includes integration of primary and specialty care. This pilot will test the hypothesis that the quality of care for patients with cancer can be improved through the integration of primary care, oncology care, and palliative care, and the cost of care can be moderated for this disease process. The financial incentives being proposed are intended to improve the coordination of care for the attributed patients, which is entirely consistent with the goals of the Blueprint. The initial attribution of patients to the pilot will be based on the Blueprint Attribution Criteria, and then narrowed on the basis of specific diagnoses identified in the Panelization Criteria.

How will the pilot enhance coordination of patient care and provide for a focus on prevention and promotion of wellness?

In addition to the coordination of patient care described above, plans are being developed to insure that patients are counseled on proper diet, exercise, and supportive counseling in order to enhance the likelihood of full recovery and restoration to an active and healthy lifestyle.

How will provider compensation encourage adherence to clinical standards, and achievement of desired outcomes for the patients?

Primary care providers will receive compensation for developing and monitoring the multi-disciplinary care plan and for incorporating palliative care services into the care planning at the beginning of treatment. These relatively small measures provide more structure than currently exists to the treatment process, and establishes expectations regarding provider adherence to clinical protocols or clear documentation of the reasons why protocols should be changed. This creates a continuous communication loop among all the providers involved in a specific patient's care and treatment and provides opportunities for education and improvement as protocols are revised. In this case, it is not so much the money as it is the delivery system changes that we believe will result in improved care and reduced cost.

How will the pilot encourage integration of mental and physical health care services?

As with any chronic condition, depression is a common symptom that will need to be addressed. Behavioral Health Services are currently available through NCHC and these services are intended to be incorporated as part of the multi-disciplinary care plan.

Proposed Timeline – See Addendum 2

Addendum 1

Panelization criteria for patients in the VT Oncology Pilot

5/31/12

These criteria are designed to be as consistent as reasonably possible with the Vermont Blueprint. Participation in the Oncology Pilot will be voluntary for the patients.

- Patients
    - **Must be Blueprint-attributed to a practice in the St. Johnsbury area**
    - Are enrolled with a Vermont payer:
        - As a Medicaid/Medicare patient OR a member/beneficiary of a commercial insurer:
            - Patient resides in Vermont
        - As a member/beneficiary of an employer-provided health plan:
            - Employer is in Vermont
    - 18 years of age or older (Criterion for NCCC to treat as adults)
    - Seen on or after Jan 1, 2010, including current patients

- By specified Providers (see separate provider list)
    - PCPs, including NPs, PAs and physicians (some patients' PCPs are NPs or PAs)
        - Northern Counties Health Care – 13 PCPs
        - NVRH – 13 PCPs
        - Goal going forward: use Blueprint PCP attribution
    - Surgeons, oncologists, and palliative care providers
        - NVRH
        - DHMC/NCCC
    - Note that network leakage will occur: PCPs will panelize patients who may receive care elsewhere. We will do a payer run to estimate this leakage to other provider organizations, e.g. Fletcher Allen. We may need a flag in the record to indicate they have left the network.
- Diagnosis of any cancer, all stages, and all cell types with the exception of limited depth melanoma & basal cell and squamous cell cancers of the skin.
    - Documented in one of the project systems at DHMC, NCCC, NVRH, or NCHC.
    - ICD-9 codes to include:

ICD9 code	Description
140-172, 174-199	Malignant neoplasms except basal cell and squamous cell cancers of the skin
200-209	Lymphatic & hematopoietic neoplasms, neuroendocrine tumors
230-234	Carcinoma in situ

- Receiving care at NVRH or DHMC/NCCC (some patients will be lost to network leakage)
- All payers included (Note that Medicare is not yet on board, but Medicaid is)

Addendum 2

Proposed Timelines
For The St. Johnsbury
Oncology Project

Micro-Pilot Begins

-2 Current Cancer Patients	July 1, 2012
-10-20 Newly Diagnosed Patients Added	August 1, 2012
-Add Existing Cancer Patients*	October 1 –December 31, 2012
-Add Newly Diagnosed Patients*	October 1, 2012 and onward
(*PPPM Payments begin in October)	

Care Plan

-Initial Care Plan Approved	June 14, 2012
-Care Plan Implemented and Elements Scanned Into MEDITECH EMR (NVRH + NCHC)	July 1, 2012

Performance Measures

-Initial Phase 1 Performance Measures Approved	June 20, 2012
-Phase 2 Performance Measures, Protocols, Etc.	TBD

Payment Model

-Initial PPPM Implemented	October 1,

Pilot Evaluation and Report Due July 1, 2013

-Report on clinical improvement,
Patient experience, and cost and
Utilization of services.

Addendum 3

Utilization and Savings Chart

Northeast Vermont Oncology Pilot - July 1, 2012									
State-Wide			**Current 4 Year Expenditures**			**Potential 4 Year Cost Savings**		
	Insurance Type	Number Individ.	Total Payments	Cost/Capita		5% Savings	7% Savings	10% Savings
	BC/BS	2,551	$ 185,127,276	$ 72,570		$ 9,256,364	$ 12,958,909	$ 18,512,728
	CIGNA	2,054	$ 146,959,373	$ 71,548		$ 7,347,969	$ 10,287,156	$ 14,695,937
	MVP	996	$ 68,724,885	$ 69,001		$ 3,436,244	$ 4,810,742	$ 6,872,489
	TVHP	854	$ 54,800,885	$ 64,170		$ 2,740,044	$ 3,836,062	$ 5,480,089
	WELLPOINT	527	$ 43,762,333	$ 83,040		$ 2,188,117	$ 3,063,363	$ 4,376,233
	CBA	269	$ 21,390,883	$ 79,520		$ 1,069,544	$ 1,497,362	$ 2,139,088
	APEX	243	$ 15,476,008	$ 63,687		$ 773,800	$ 1,083,321	$ 1,547,601
	AETNA	172	$ 9,530,428	$ 55,409		$ 476,521	$ 667,130	$ 953,043
	BC/BS/MASS	160	$ 11,872,127	$ 74,201		$ 593,606	$ 831,049	$ 1,187,213
	UNITED	149	$ 11,629,780	$ 78,052		$ 581,489	$ 814,085	$ 1,162,978
	OTHER	280	$ 19,599,753	$ 69,999		$ 979,988	$ 1,371,983	$ 1,959,975
	Total Commercial	8,255	$ 588,873,731	$ 71,335		$ 29,443,687	$ 41,221,161	$ 58,887,373
	MEDICAID	1,549	$ 100,685,832	$ 65,001		$ 5,034,292	$ 7,048,008	$ 10,068,583
	Total All Payers	9,804	$ 689,559,563	$ 70,335		$ 34,477,978	$ 48,269,169	$ 68,955,956
St. Johnsbury HSA								
			Current 4 Year Expenditures		**Proposed 4 Year Investment**	**Potential 4 Year Cost Savings**		
	Insurance Type	Number Individ.	Total Payments	Cost/Capita		5% Savings	7% Savings	10% Savings
	BCBS/TVHP	76	$ 6,319,065	$ 83,146	$ 291,840	$ 315,953	$ 442,335	$ 631,907
	CIGNA	68	$ 5,070,355	$ 74,564	$ 261,120	$ 253,518	$ 354,925	$ 507,036
	MVP	19	$ 1,575,857	$ 82,940	$ 72,960	$ 78,793	$ 110,310	$ 157,586
	ALL OTHER	5	$ 884,376	$ 176,875	$ 19,200	$ 44,219	$ 61,906	$ 88,438
	Total Commercial	168	$ 13,849,653	$ 82,438	$ 645,120	$ 692,483	$ 969,476	$ 1,384,965
	Medicaid	102	$ 6,029,475	$ 59,113	$ 391,680	$ 301,474	$ 422,063	$ 602,948
	Total All Payers	270	$ 19,879,128	$ 73,626	$ 1,036,800	$ 993,956	$ 1,391,539	$ 1,987,913